



Commonwealth of Kentucky
Environmental and Public Protection Cabinet

Office of Mine Safety and Licensing
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EMERGENCY AWARENESS BULLETIN

To: All District Supervisors, Inspectors, Analysts and Instructors
From: Ronald H. Hughes – Director, Division of Investigation
Date: May 01, 2006

EAB-06006 Kentucky Fatal No. 5 (Nationally # 26) Machinery

On April 21, 2006, at approximately 4:30 AM, a mechanic was found fatally injured in an underground mining accident in the Harlan District. The victim was 45 years of age, with a total of 17½ years of mining experience. The victim had 11 years with this company and 5 years of this experience in his present occupation as a mechanic. There were no known eyewitnesses to this accident.

The mine is a three unit mine and employs a total of 141 employees and has two coal producing shifts with one maintenance shift. The victim worked on the maintenance shift which normally began at 11:00 pm and ended at 9:00 am.

The mechanic (victim) for the mobile bridges on MMU 002-0 was a part of an eight man crew assigned to make a belt set up on this working section. The victim had been assigned to troubleshoot the problem of weak tram on the left side of the No. 1 bridge also known as the No. 4 Breaker Car Module (BCM). According to testimony the victim began troubleshooting the No. 1 bridge at 3:00 AM. At approximately 4:30 AM, a fellow coworker found the victim pinned between No. 1 bridge operator's compartment and the lo lo belt structure. The coworker immediately sought help. The victim having no vital signs was removed from between the equipment. CPR began immediately and was continued while the Medical Emergency Technicians prepared the victim for transportation on a stretcher via a diesel man trip to the surface. An ambulance crew relieved the MET's upon their arrival on the surface. At this time the victim was transported to the Harlan Appalachian Regional Hospital where he was pronounced dead by the emergency room physician Doctor Amir Ahmad at 6:25 AM.

The accident is currently under investigation by the Office of Mine Safety and Licensing and the Mine Safety and Health Administration.

PREVENTATIVE MEASURES:

1. Never place yourself or others in a pinch point areas where there is equipment in operation.

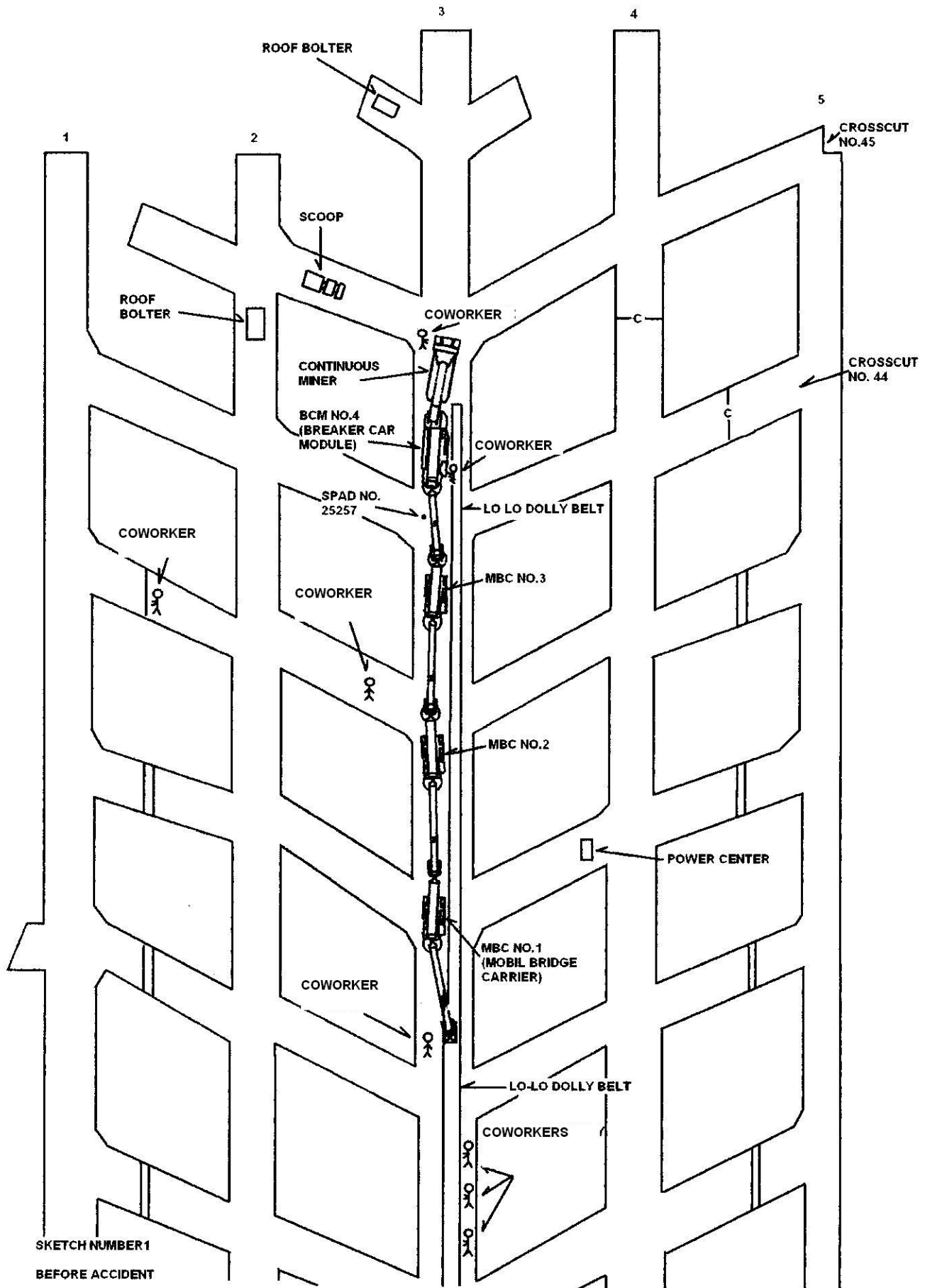
Remember, all accidents are preventable. We simply fail to prevent them.



COAL CO
FILE NUMBER - XXXX
HUFF CREEK MINE NUMBER 1
FATAL ACCIDENT

INC

SEVEN NORTH SECTION



SKETCH NUMBER 1

BEFORE ACCIDENT

SKETCH NOT TO SCALE

EMPLOYEES POSITION PRIOR TO ACCIDENT

COAL CO

FILE NUMBER XXXX

MINE NUMBER 1

FATAL ACCIDENT

COWORKER

CONTINUOUS MINER - DETACHED

ENTRY WIDTH WAS 20 FEET

HEIGHT AT THE ACCIDENT SCENE
WAS 8 FEET AND 11 INCHES

LEFT COAL RIB

RIGHT COAL RIB

48 INCH LO-LO DOLLY BELT

BCM
BREAKER CAR
MODULE NO. 4

17 INCHES OF CLEARANCE BETWEEN THE
LO-LO DOLLY BELT STRUCTURE AND THE
BREAKER CAR FRAME

VICTIM

CROSS CUT NUMBER 44

48 INCH LO-LO DOLLY BELT

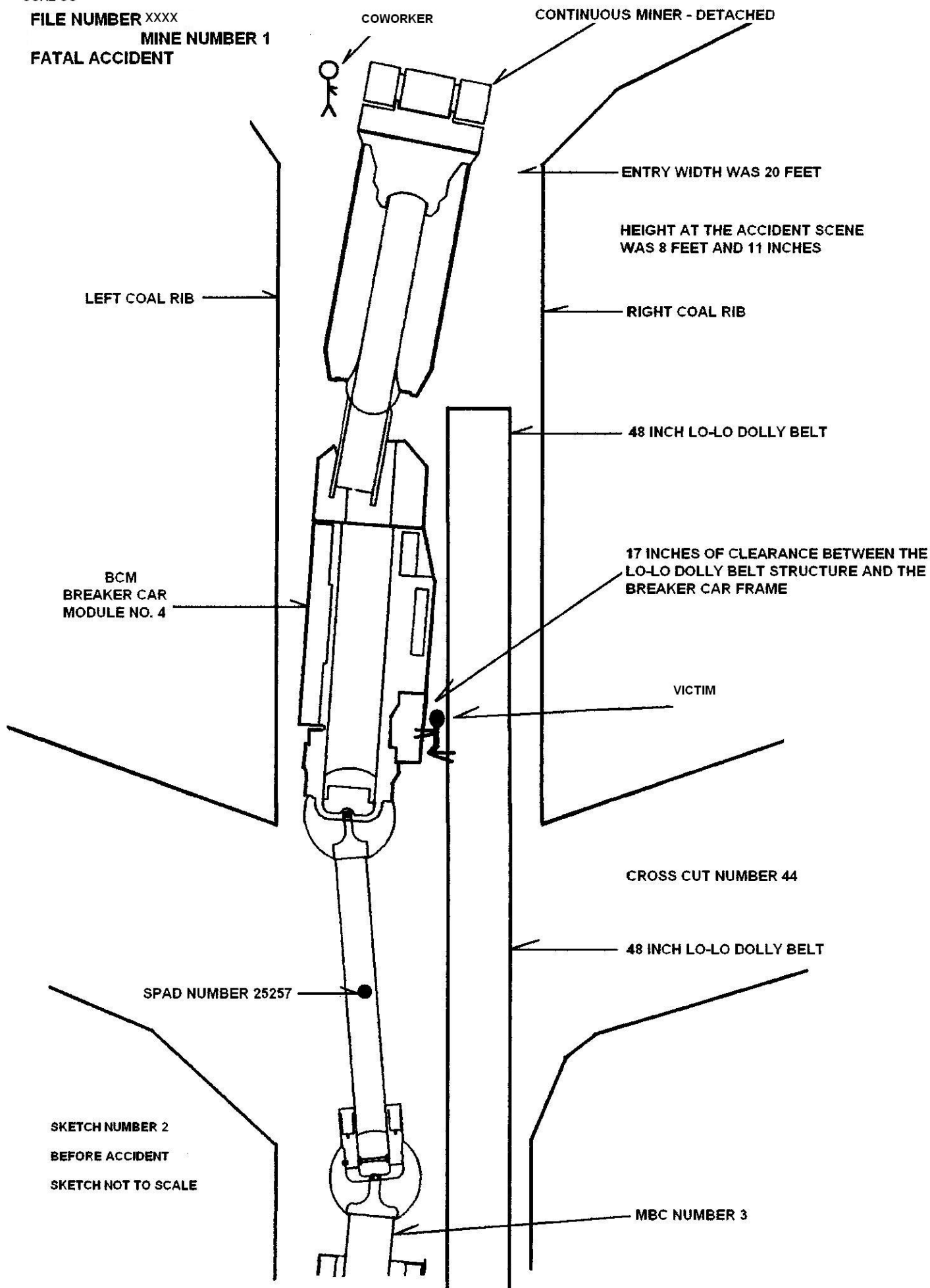
SPAD NUMBER 25257

SKETCH NUMBER 2

BEFORE ACCIDENT

SKETCH NOT TO SCALE

MBC NUMBER 3

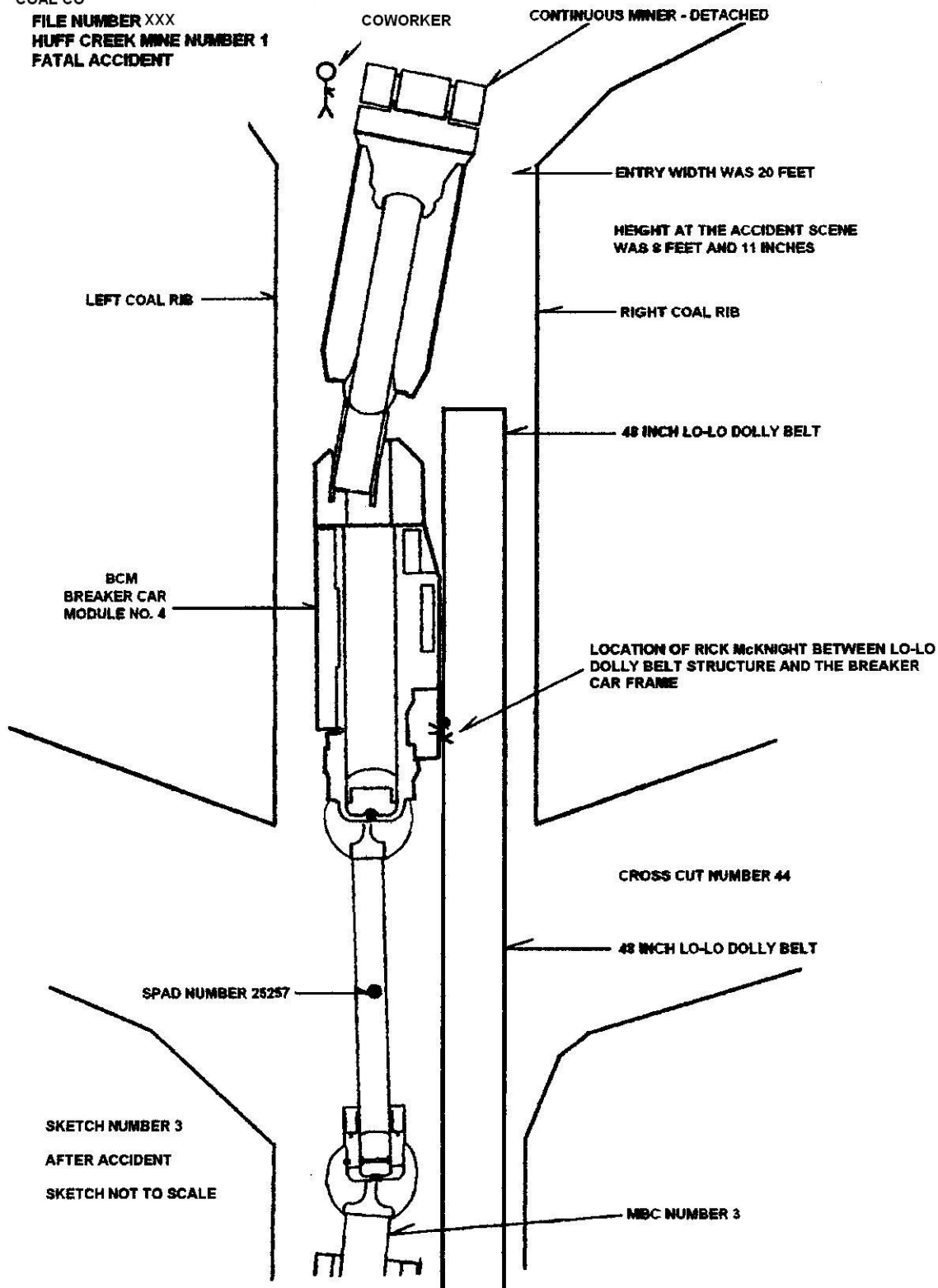


COAL CO

FILE NUMBER XXX

HUFF CREEK MINE NUMBER 1

FATAL ACCIDENT



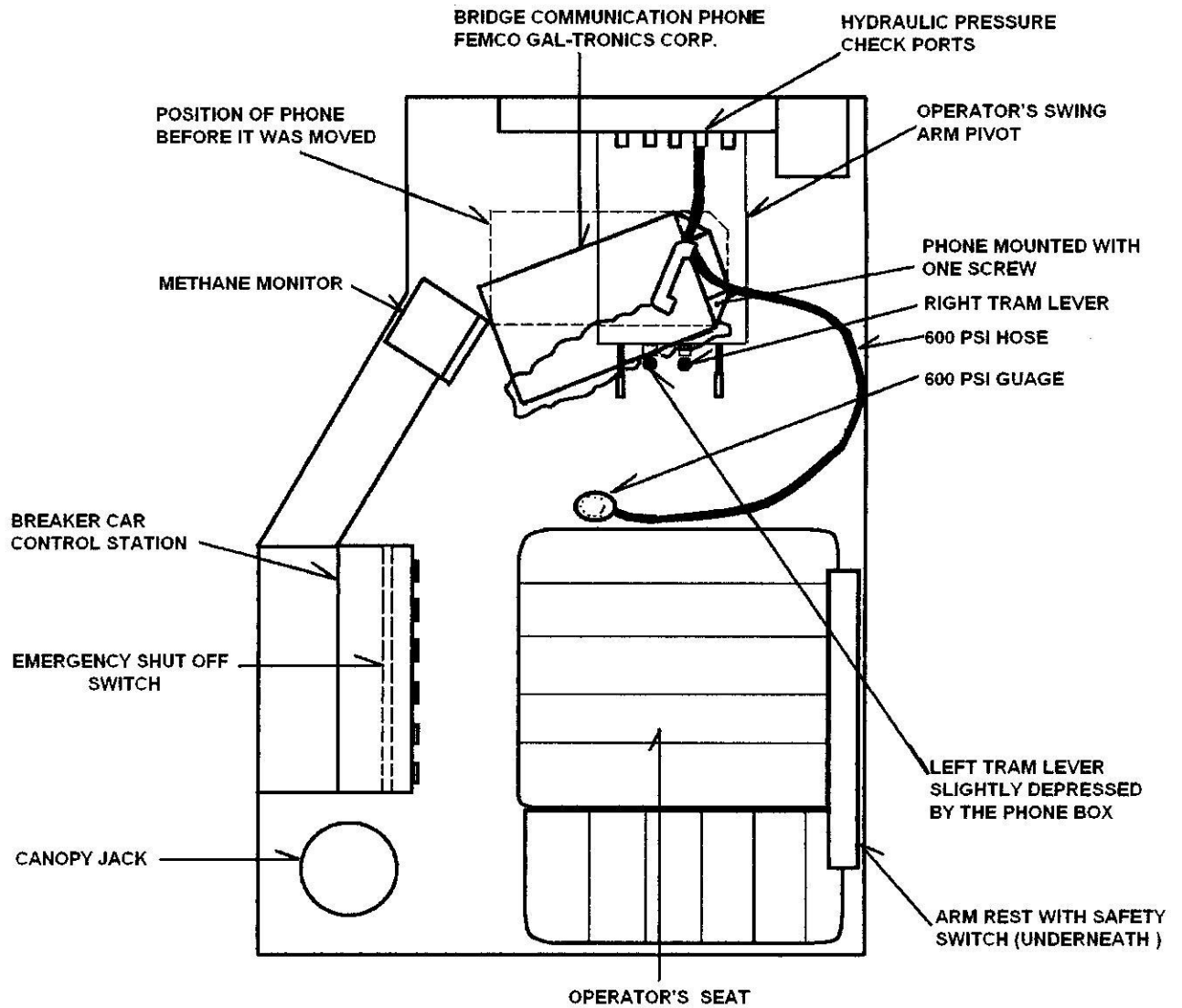
COAL CO

FILE NUMBER XXX

MINE NUMBER 1

FATAL ACCIDENT

OPERATORS COMPARTMENT



SKETCH NUMBER 4

OPERATORS COMPARTMENT AS
FOUND AFTER THE ACCIDENT

SKETCH NOT TO SCALE